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ABSTRACT

The information about Acquired Immune Deficiency Syndrome (AIDS) presented in this special report is designed to encourage the development of educational and preventive programs on the college campus. Chapter 1 defines many of the words and phrases used in discussions about AIDS; tells how the disease is and is not spread; and briefly discusses testing, treatment, and prevention. Chapter 2 discusses the impact the Human Immunodeficiency Virus (HIV) has on higher education campuses, the risk factors that exist for students, education and service programs and their costs, and the kind of education needed to prevent HIV infection. Chapter 3 examines the various areas that should be of concern to governing boards in dealing with the AIDS issue including: (1) overseeing and monitoring the institution's policies and programs for students and employees; (2) managing the institution's resources and analyzing the potential impact of HIV infection; (3) evaluating the institution's role as leader, partner, and resource; and (4) determining positions on the social and ethical issues related to the disease. The fourth and final chapter presents guidelines and recommendations for HIV infection and AIDS prevention activities on campus. An appendix provides the American College Health Association's statement on institutional response to AIDS. (GLR)

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AGB SPECIAL REPORT

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What Governing Board Members Need to Know About AIDS

By Dr. Richard P. Keeling, M.D.

Made possible by a grant from The Hitachi Foundation

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Foreword

AIDS is one of the most serious health problems the world has ever faced. February 1990 statistics show an estimated 1 million Americans are infected with the AIDS virus—a 33 percent increase over the past three years, according to a report from the federal Centers for Disease Control. Thousands of AIDS victims are teenagers and young adults—the population that unequivocably represents the heart of our colleges and universities and the future of our nation.

Members of governing boards and institutional administrators are obligated to their students, employees, and society to confront the epidemic by developing education and prevention programs and by ensuring protection from accidental exposure in on-campus health-care professions and HIV-related services.

However, trustees frequently are apprehensive about the appropriateness of AIDS education and the reactions of the public to sexual-health promotion programs. These concerns might include the possibility of negative press and media coverage, lost support, antagonism or strain in public relations, and a siphoning of enrollment. Such concerns are not unrealistic, but they must be balanced against the possible consequences of inaction.

Certainly, specific institutions will face specific challenges. State laws and policies might limit the flexibility of some colleges and universities in responding to AIDS. Institutions affiliated with religious orders or that have certain governance procedures might face difficulties by taking any action that seems inconsistent with doctrine or mission—or, alternatively, by failing to take such action.

In any case, all of us, including governing board members, need more information about AIDS. Board members can begin with this Special Report, written by Richard P. Keeling, M.D., and funded by The Hitachi Foundation of Washington, D.C. Dr. Keeling, director of the department of student health at the University of Virginia and the president of the American College Health Association, is an acknowledged expert on the subject of AIDS and has served at the intellectual and academic forefront of the public issues since the early 1980s.

Dr. Keeling has participated as a member of the U.S. Public Health Service's Ad Hoc Committee on AIDS, as the chair of the Task Force on AIDS with the American College Health Association, and as an executive board member of the National AIDS Network. Additionally, he serves as a consultant on AIDS issues to more than 70 colleges and universities.

Undoubtedly, you will find the first chapter of this Special Report stark in nature and liberal in description. Nonetheless, careful review of this segment of the report provides a basis of knowledge and understanding that is vital in ministering to your students, your employees, your institution, and ultimately, to higher education.

The Association of Governing Boards of Universities and Colleges is grateful to The Hitachi Foundation for sponsoring this important work and to Dr. Keeling for alerting governing board members to the need to respond.

Robert L. Gale
President
Association of Governing Boards
of Universities and Colleges
Washington, D.C.

Dedication

For Miguel Garcia-Tunon: 27 years were not enough.

Acknowledgements

This Special Report rests on the solid foundation of leadership provided by my colleagues on the Task Force on HIV Infection and AIDS of the American College Health Association. Their ideas, experience, and vision live in these pages.

The University of Virginia and its officers and Board of Visitors have offered the institutional, collegial, and moral support necessary for my work. I especially appreciate the patience and commitment of my friends in the Department of Student Health. My assistant, Mrs. Mary Syrus Anderson, has become legendary for her helpfulness; this text is also evidence of her indispensibility.

And, about my wife, Arlene, and my children, David, Jennifer, and Amy, not enough can be said: they are, as they ever have been, always there with me.

Dr. Richard P. Keeling, M.D.
Charlottesville, Va.

CHAPTER 1
HIV Infection and AIDS

Before college and university officials can develop educational and other programs that respond appropriately to AIDS, it is important for everyone involved to understand the facts about this disease. This chapter defines some words and phrases you might have heard regarding AIDS, tells how the disease is and is not spread, and briefly discusses testing, treatment, and prevention.

The Spectrum of Human Immunodeficiency Virus Infection

AIDS—Acquired Immunodeficiency Syndrome—is the most advanced phase of disease caused by the Human Immunodeficiency Virus (HIV). People who have been infected with HIV might experience no symptoms, some symptoms, or extensive symptoms along a broad continuum of clinical conditions; this entire continuum represents HIV-related disease. The inclusive term *HIV Spectrum Disease* defines this continuum.

HIV-infected people tend to progress along the continuum over time from one phase of infection to the next. Unless treatment is administered to alter this progression, infected people usually will shift gradually from displaying no symptoms to displaying some symptoms and eventually to displaying advanced symptoms. This "natural history" of HIV infection appears fairly predictable in the absence of treatment. Although some health officials once believed that many people with HIV infection would remain permanently symptom-free, the current understanding is that most, if not all, HIV-infected people will proceed through a series of phases that ultimately lead to serious illness.

We can identify four major phases of HIV-associated disease:

- **1. Acute infection.** In the first few weeks after exposure to HIV, an infected person might develop a transient, flu-like or mononucleosis-like illness that generally recedes without therapy. Most of these illnesses are so nonspecific that they are not recognized or diagnosed.
- **2. Asymptomatic infection.** HIV infection is characterized by a long latent phase or incubation period. Current observations estimate the average incubation period for sexually transmitted infection (from day of infection with HIV to day of diagnosis of actual AIDS) at almost ten years. Generally during this period, people experience few or no symptoms that can be related to HIV. However, even if no symptoms are present, infected people are able to transmit HIV—

that is, they are infectious. Most people with asymptomatic HIV infection are probably unaware of their infection.

Even when symptoms are absent, HIV infection can be diagnosed through blood tests that detect antibodies to the virus, a fragment of the virus itself, or a portion of the genetic material of the virus. Most clinical inspection of individuals and screening of blood for transfusion is conducted using antibody tests. These tests reliably can identify antibodies to HIV four to six months after infection has occurred.

Once the results appear positive, they routinely remain positive for the rest of the victim's life. No laboratory test exists for AIDS itself; the available tests simply determine whether an individual is infected with HIV.

■ **3. Chronic symptomatic disease.** During the latent phase, people with HIV infection might not have any symptoms whatsoever for many years. Over time, however, certain symptoms often develop—enlarged lymph nodes, mild weight loss, minor skin rashes, and mouth ulcers, for example. These symptoms might intensify gradually, but a waxing-and-waning pattern also is typical.

During the chronic symptomatic phase, laboratory studies of the function of the immune system demonstrate periodic deterioration. The transition from chronic symptomatic disease to advanced immune deficiency (which we now call AIDS) is often heralded by certain specific clinical events, such as thrush (a fungal infection in the mouth) or shingles (a reactivation of the chicken pox virus infection that causes pox-like rashes and pain along the distribution of some nerves). This chronic symptomatic phase often has been referred to as "AIDS-Related Complex," or ARC.

■ **4. Advanced symptomatic disease.** When certain serious or life-threatening complications arise, people with HIV infection are considered to have advanced disease, or AIDS. This advanced phase sometimes has been called "Full-Blown AIDS" to distinguish it from earlier phases of HIV-associated disease. The diagnosis of AIDS is based on a group of major manifestations:

Opportunistic Infections. Opportunistic infections are caused by microorganisms that, due to the protection provided by the immune system, ordinarily are unable to cause disease. When the immune system becomes deficient, these microorganisms take advantage of the deficiency and generate illness. Opportunistic infections are the basis of the overwhelming majority of employee-absentee days, hospitalizations, costs, and deaths from HIV disease. The most common and significant of these infections include the following:

- Pneumonia caused by *pneumocystis carinii*, a lung parasite;
- Meningitis, an infection of the lining of the brain and spinal cord caused by a fungus called *cryptococcus neoformans* or by other organisms;
- Disseminated infection and retinitis, an infection of the retina causing loss of vision, related to cytomegalovirus.

Unusual Cancers. People with advanced HIV disease might develop certain cancers, especially the following:

- Kaposi's sarcoma, a tumor of the skin and mucous membranes that appears as purple lesions; and

■ Lymphomas, tumors of the lymph nodes that are much more difficult to treat than the lymphomas occurring in individuals who aren't HIV infected.

Neurologic Disease. A significant minority of people with HIV disease develop central-nervous-system manifestations. Pain, alterations in sensation or movement, changes in memory or thinking ability, and emotional disorders might occur. A dementia that resembles Alzheimer's Disease evolves in some people with HIV disease.

Wasting Syndrome. Many people with HIV disease lose weight for a complex variety of reasons. A minority of these people lose extensive amounts of lean body mass and become emaciated. This wasting syndrome causes severe weakness and disability.

A number of factors, sometimes called *cofactors*, might influence the speed with which people progress along the continuum of HIV disease. The better a person's general health, the more slowly progression seems to occur. Although it has been difficult to prove in scientific studies, many clinicians caring for people with HIV infection believe that alcohol, recreational drugs, stress, and poor nutrition contribute to acceleration of the course of HIV disease.

The mechanism of infection seems to be relevant: People infected by inoculation of HIV into the bloodstream, as by transfusion of infected blood or needle sharing, generally develop symptoms more quickly than people infected by sexual contact.

Characteristics of Human Immunodeficiency Virus

HIV is a human retrovirus, a virus that contains RNA in its genetic material. The virus must convert this RNA to DNA when it infects human cells. HIV is highly selective in infecting cells and will enter only those cells that contain a specific protein receptor for the virus. The major targets for HIV are certain cells that operate the immune system; the primary cell infected is called a *helper lymphocyte*, or T4 cell.

The origin of HIV is uncertain, as is its future; although many minor mutations in HIV have occurred, none has significantly changed its properties or its virulence.

Transmission and Epidemiology of HIV

After many years of careful, detailed epidemiologic and virologic research, the transmission of HIV is well understood. HIV is transmitted only by certain body fluids that contain sufficient concentrations of the virus to cause an infection in a recipient. Notably, HIV is transmitted by semen, cervical and vaginal secretions, and blood and blood products; it *might* be transmitted by breast milk from a mother to her infant. *It is clear that HIV is not transmitted by saliva, tears, perspiration, or urine.*

The routes and mechanisms of transmission of HIV are quite predictable and clear:

1. Sexual contact. On a worldwide basis, the overwhelming majority of HIV infections result from transmission of the virus during unprotected sexual intercourse. Anal (penis in anus) and vaginal (penis in vagina) intercourse both

are associated with transmission of HIV to either partner. Some gradations of risk might exist, but precise levels and significance are not yet certain. Generally, however, anal intercourse seems more likely to allow transmission of HIV than vaginal intercourse, and performance as the receptive partner (male or female) rather than the insertive partner in anal or vaginal intercourse seems more likely to result in infection.

The risk of transmitting HIV during oral sex performed on a male (fellatio) is low but uncertain; the risk seems dramatically lower than that associated with anal or vaginal sex. The risk of transmitting HIV during oral sex performed on a woman (cunnilingus) also is uncertain, but similarly seems low.

There is no serious concern about transmitting HIV through kissing—no case of HIV infection related to kissing is known. Although theoretical risks of transmission are related to bleeding gums, mouth ulcers, and so forth, no valid observations of such transmission exist.

Artificial insemination has transmitted HIV from an infected semen donor. The risk is nearly negligible when frozen semen from double-screened donors is used.

2. **Direct exposure to infected blood.** Blood-related transmission of HIV has occurred through the following activities:

- **Needle sharing.** In the United States and many Western countries, blood contained in shared needles is responsible for an increasing percentage of HIV infections. Most needle sharing occurs in relation to intravenous drug use, whether by occasional or habitual users.

Among young people enrolled in colleges and universities, however, much needle sharing occurs not for recreational drugs, but for anabolic steroids. Steroids often are injected by athletes and nonathletes in an attempt to build muscle bulk for appearance or for athletic prowess. If the needles used to inject the steroids are shared, HIV or other blood-borne infectious organisms might be transmitted.

- **Transfusion of blood and blood products.** The combination of donor self-exclusion programs and the screening of all donated blood has resulted in a safe blood supply in the United States. However, a very small risk of HIV infection still is associated with transfusion, because some people who have HIV infection might donate blood before they are aware that they are infected. Estimates of the risk of acquiring HIV through blood transfusion are somewhere between one in 60,000 and one in 100,000.

Better processing techniques also have reduced the risk of HIV infection from treating hemophilia (bleeding disorders) with concentrated blood-clotting treatments. Many people with hemophilia, however, were treated with HIV-infected clotting-factor concentrates before 1985.

Organ transplantation also might cause HIV infection if the organ donor was infected. This risk has been greatly reduced through the implementation of donor-screening programs.

- **Accidents in health care.** A small number of clinical and laboratory workers in health-care and medical-research professions have been infected with HIV as a result of accidents involving direct exposure to HIV-infected blood. Most of these infections have occurred following incidents in which sharp objects containing HIV-infected blood penetrated the skin or mucous membranes of health-

care workers. Using universal precautions in health-care occupations will reduce the risk of injury and infection substantially.

3. Perinatal transmission. The offspring of an HIV-infected woman might be infected before, during, or just after birth. Thirty to sixty percent of children born to HIV-infected women actually become infected. Some of these infections clearly occur during pregnancy; others seem to manifest at birth. A few cases exist involving HIV-infected babies who probably were infected through breastfeeding.

It is quite clear that HIV is not transmitted by ordinary, nonintimate interpersonal contact of any kind. Detailed studies of the contacts of HIV-infected individuals have proved that the only people who acquire HIV infection are the sexual or needle-sharing partners of the source person. HIV is not transmitted through the air or in water; using the same swimming pool, sauna, hot tub, or shower as a person with HIV infection creates no risk. HIV is not spread through coughing or sneezing. The only object that has transmitted HIV from one person to another is a needle. No evidence whatsoever exists to prove that animals, birds, or insects can transmit HIV from one person to another; in fact, excellent evidence exists that mosquitoes do not transmit HIV.

The epidemiology, or pattern of spread, of HIV generally is well known. It is clear that *risk behaviors* such as unsafe sexual contact and needle sharing, not *risk groups*, are the source of infection. People historically considered at greater risk of having HIV infection include the following:

1. Men who have sex with men. The labels "homosexual" or "bisexual" are not significant; the *behavior* of having unprotected sex with another man is significant. Many men who have had sex with another man do not consider themselves homosexual or bisexual. Many men who have had sex with another man are married; many have, or will have, children. In a student community, much same-gender sexual behavior often is experimental and unacknowledged.

Historically, a majority of people with AIDS (advanced HIV disease) in the United States are gay or bisexual men. The dramatic changes in behavior in gay communities in the mid 1980s have resulted in a decrease in the rates of HIV infection, and the percentage of gay men among people with AIDS has begun to drop substantially.

2. People who share needles. Most needle sharing occurs among users of illicit drugs, including heroin and cocaine. However, needles also are shared among those who inject anabolic steroids, most notably college athletes. Intravenous-drug users comprise a rapidly rising proportion of people with HIV infection and AIDS in the United States; effective risk-reduction programs for drug users have not been clearly identified, and the best strategies for outreach and rehabilitation are not clear.

In some urban areas, the percentage of people who have acquired HIV through sharing needles is significantly higher than the percentage of people who have acquired HIV infection through sexual contact.

3. People who have had heterosexual intercourse with HIV-infected individuals. The most important focus of heterosexual transmission of HIV in the United States so far has been among the sexual partners of intravenous-drug users. Young adults who are not drug users but who do have multiple sexual

partners also might be at relatively higher risk of HIV infection than other segments of the population.

The percentage of AIDS cases occurring in people who were infected during heterosexual intercourse has risen slowly for several years and is expected to continue to rise gradually through the 1990s.

4. Recipients of HIV-infected blood or blood products. The combination of effective donor self-exclusion programs and universal screening of donated blood for antibodies to HIV has reduced the likelihood of new HIV infections through blood or blood-product transfusion. However, people who received infected blood prior to 1985 still might develop HIV-related illness, and a small number of new transfusion-related cases of HIV infection will continue to occur.

Testing for HIV Infection

Several different types of laboratory tests document the presence of HIV infection. Some tests directly detect fragments of the virus itself (HIV antigen) or portions of the genetic material of HIV (by polymerase chain reaction). Most HIV testing, however, is conducted using tests that identify antibodies to the virus; the existence of antibodies indicates that an immune response to HIV has occurred and therefore determines that HIV infection is present.

Antibody testing, whether conducted for clinical reasons or for blood screening, requires a two-step process: an initial screening test (ELISA test) and, if that test is positive, a confirmatory test (usually conducted utilizing a procedure called the Western Blot). Confirmation of positive ELISA tests is necessary, because false test results can occur.

The antibody tests appear positive in most people approximately within six months after infection with HIV. Therefore, a substantial "window period" occurs just after infection, during which an HIV-infected person can transmit the virus but yields a negative antibody test. The window period is responsible for false negative tests. In some cases, a person might not develop antibodies to HIV for 12–18 months, and rarely even for two or three years, after infection.

A confirmed positive test indicates that an individual is infected with HIV. The tests are not conducted to pinpoint any clinical consequence of HIV infection, such as AIDS. A negative test either can mean that an individual is not infected with HIV or that the test was performed prior to the development of antibodies. When any doubt exists about the timing of the test *vis a vis* the last possible exposure to HIV, it is appropriate to repeat the procedure several months later.

Treatment of HIV Disease

HIV-disease treatment is steadily improving, and different approaches to treatment exist for different phases of HIV disease. Such treatments include the following:

■ **1. Early intervention for asymptomatic or mildly symptomatic HIV infection.** Zidovudine (formerly called azidothymidine, or AZT) is an antiviral drug that meaningfully can delay the development of severe symptomatic HIV disease among HIV-infected people who have either no symptoms or mild symptoms and who have certain levels of immunologic function. This treatment is quite

expensive and might be inaccessible for many people; although the physical side effects of zidovudine used in this treatment are few, the psychological adjustment to chronic illness might be difficult.

Zidovudine therapy does not replace the other self-directed health-preservation techniques that preceded it. Healthy diets, exercise programs, stress reduction, spiritual and psychological peace, and adequate sleep and rest all are important therapeutic factors for HIV-infected people. Zidovudine therapy for asymptomatic or mildly symptomatic people is significant because it contributes to rendering HIV disease a chronic manageable illness.

- **2. Preventing complications.** Certain vaccines and antibiotics might prevent infectious complications for HIV-infected people who are or are not exhibiting symptoms. Some of the medications involved are toxic and expensive but could prevent hospitalizations and serious illness.
- **3. Treating severe HIV disease.** Better therapies for the cancers and infections associated with severe HIV disease, combined with zidovudine therapy for the HIV infection itself, have greatly improved both the quality and length of life for people with AIDS. Effective treatments can allow people with AIDS to continue to work or study much longer. New outpatient approaches to health care for people with AIDS have reduced hospital time and the frequency of hospital-associated complications.

Although no cure for HIV disease exists, the clinical tools available allow optimism that people with HIV disease might live long enough to benefit from better treatments and strategies being developed and tested. Early intervention in HIV disease offers the greatest hope of preserving health.

Prevention of HIV Infection

HIV infection cannot be prevented by vaccination. Although many research projects are in progress, it is unlikely that a clearly effective, safe, affordable, marketable HIV vaccine will be available in the next few years. Technological prevention is, then, as yet unattainable. However, because HIV is transmitted only through easily identifiable methods, preventing HIV infection still is possible using the powerful strategy of effective education for behavior change.

CHAPTER 2

The Impact of HIV Infection on Higher Education

HIV infection already has had a significant impact on college and university campuses. Higher education communities certainly will experience additional consequences of the epidemic during this new decade. Preventing HIV infection through effective education programs is an unmet goal; compassionate and helpful services for students, faculty, or staff infected with HIV still are being developed. Institutions only are beginning to recognize the costs associated with HIV infection, and most colleges and universities have not adequately addressed the social issues the epidemic creates.

People With HIV Infection

Only a small number of the reported cases of AIDS has occurred in the traditional undergraduate age group. Counting systems do not exist that can enumerate the number of students with AIDS. But the absolute number of AIDS cases *documented* among college and university students is a poor indicator of the epidemic's significance on campus. Because HIV causes a continuum of conditions, its impact can be estimated only by measuring the frequency of the infection itself. Studies of the frequency of infection are based on antibody testing conducted to identify those infected.

Preliminary studies by the American College Health Association and the national Centers for Disease Control, an agency of the United States Public Health Service, have provided one indicator of the prevalence of antibody to HIV among students: Of approximately 17,000 students tested through student-health centers on 19 campuses in the United States, roughly two of every 1,000 students are HIV infected. More detailed and sophisticated studies will monitor trends in the rate of infection over time and produce a better picture of the frequency of infection in different student groups, on campuses of various types, and in regions of high, medium, or low frequency of diagnoses of AIDS.

Although it would be premature and inaccurate to interpret this initial prevalence data so literally as to suggest that two of every thousand students on every campus already is HIV infected, it is important at least to understand that the early studies confirm that HIV is present in campus populations. This is, of course, not unexpected. AIDS is a disease primarily of young people; the average age at the

time of diagnosis is only in the early thirties. Most people with AIDS are 25-45 years of age. Because the latency period between date of infection and date of diagnosis of severe immune deficiency averages approximately a decade, it is logical to conclude that HIV infection usually is acquired at the ages between the late teens and the late twenties. Most college and university students are in that age group.

People in a campus community who actually are diagnosed with AIDS are likely to be older than traditional undergraduates. HIV infection acquired during high school or the first years of college is unlikely to be diagnosed as AIDS until after undergraduate commencement. Graduate and professional students, nontraditional or returning undergraduates, and members of the faculty and staff are far more likely to experience AIDS itself than are traditional undergraduates. Additionally, many institutions now have had experience with employees who have AIDS or other symptomatic illnesses caused by HIV.

As the average age of students rises, more and more institutions will be confronted by the needs of those with AIDS. Students with symptomatic HIV disease, and especially AIDS itself, likely will require certain medical, psychological, and social services; institutions with a preponderance of older students are more likely to confront these needs than are primarily residential, traditional undergraduate colleges.

The urban commuter campus is, perhaps, most likely to face significant numbers of students with AIDS; many such campuses generally have not emphasized student services. As treatments for HIV disease improve, people with AIDS probably will survive longer and be able to stay in the work force or in degree programs; thus, the number of people requiring services probably will increase substantially with time.

Services cannot, however, be limited to students or employees with severe symptomatic disease. The new hope of earlier intervention in HIV infection demands that institutions focus their attention quite broadly on students and employees with any phase of HIV disease. Students must have access to antibody-testing services and, if they test positive, to medical and immunological evaluation and follow-up.

Many students with HIV infection are eligible for early treatment with zidovudine or other antiviral drugs; all are candidates for measures designed to promote general health, prevent complications, and marshal psychological and spiritual resources. Most colleges will face having to deal with asymptomatic or mildly symptomatic students far more often than with students with full-blown AIDS—but all of these students will have service needs.

An institution statistically is more likely to employ individuals with asymptomatic HIV infection rather than those with severe symptomatic disease. Obviously, officials will be more aware of the individuals with severe symptomatic disease, because asymptomatic or mildly symptomatic infection produces fewer work-related consequences. Employees with HIV disease will create demands related to disability accommodation, disability insurance, sick-leave and leave-of-absence policies, and employee-assistance programs.

Education to Prevent HIV Infection

The primary need on campus, however, is to prevent HIV infection through effective education. Effective educational programs should be available and accessible to every student and every employee on the campus. Education accomplishes several goals:

- possibly preventing new HIV infections;
- helping delay or prevent illness in people who already are HIV infected;
- reducing unreasonable fears and thereby combating prejudice and discrimination against people with HIV infection;
- promoting a compassionate and caring response to people with HIV infection; and
- drawing attention to the important economic, social, ethical, psychological, and legal issues created by the epidemic.

Education to accomplish these goals is the key responsibility of colleges and universities in addressing HIV. Effective education is a challenge; college and university officials simultaneously must work toward more successful strategies, cope with rising costs and limited resources, and confront controversy. College campuses present notable obstacles to effective health education, but also might facilitate it.

Risk Factors for College and University Students

Educating students is critically important, because real risks of HIV infection exist. College and university students comprise several developmentally distinct populations; understanding the psychological development and associated behaviors of students and incorporating this knowledge into educational strategies are vital steps in designing effective programs. Some developmental concerns that might promote risky behavior among students include the following:

- **Experimentation and invulnerability.** The attitude of "it can't happen to me" deludes students into taking risks in many situations—from driving under the influence of alcohol to delaying studying until hours before an exam. Experimental behavior seems to be an inherent part of late-adolescent and young-adult development.

The spectrum of experimental sexual behavior among students is quite broad. Research into sexual behavior among students on many campuses has shown that even the students who know about HIV and how to prevent its transmission do not consistently take precautions to protect themselves because they harbor no personal sense of risk. In other words, HIV seems to be "somebody else's problem."

- **Peer pressure and community standards.** Students might adopt the behavior standards of their peers. On many campuses, peer pressure perpetuates unhealthy behavior choices, validates the sense of invulnerability, and questions the need for and methods of risk reduction. Students might, for example, choose not to attend HIV-prevention programs if they fear, as a consequence of attendance, the negative opinions of other students.

If the peer standard is to use alcohol to reduce anxiety about sex, students might not listen to an educational message that suggests otherwise. Campuses do

not exist in isolation; the health-education and AIDS-prevention campaigns coexist with the media, including daytime television, movies, magazines—the framework of popular culture. Advertising emphasizes sexuality, attractiveness, and risk taking in promoting hundreds of products that appeal to young adults.

- **Unacknowledged sexual feelings and activity.** Students might deny sexual desire both to themselves and to others. Many students, while engaging secretly in sexual activity, espouse religious or other value systems that limit or forbid such activity. Parental instructions and personal values might be overcome by alcohol or ambivalence. Students who do not acknowledge the possibility of intercourse will not prepare for it. If intercourse occurs, it often is justified by excuses, such as the consumption of alcohol ("I must have been drunk"), urgent spontaneity ("one thing led to another and I got kind of carried away"), or innocence ("I didn't realize what was going on"). Denial and fear frequently accompany same-gender sexual attraction; some men identify themselves as heterosexual but furtively engage in unsafe sex with other men.
- **Unwanted sexual activity.** The frequency of acquaintance rape (forced sexual contact with someone with whom the victim is acquainted) is much higher on campuses than police or disciplinary reports suggest. Rape is not limited to heterosexual women; lesbians and men also are raped. Clearly, when consent is not sought, precautions to prevent transmission of HIV are not taken. And intoxification often is a major factor in acquaintance rape.
- **Needle sharing.** Studies suggest that less than 1 percent of college and university students share needles when using intravenous drugs. Needle sharing among students who are injecting anabolic steroids is more common and is not limited to competitive athletes. Comprehensive campus AIDS-education programs must, therefore, address both intravenous-drug use and steroid injection.
- **Substance use and abuse.** The significance of alcohol and recreational drugs in promoting the risk of HIV infection cannot be overemphasized. Alcohol commonly is linked to unsafe sexual contact among students. On most campuses, the majority of reported acquaintance rapes somehow involved alcohol, and many unwanted pregnancies result from intercourse in which alcohol consumption was a factor on the part of one or both partners. Alcohol can relieve a student's anxiety about sex, remove ambivalence, erase uncertainty, deaden pain, short-circuit thinking, and paralyze decision making. Sex under the influence is dangerous.
- **Low self-esteem.** Self-esteem lies at the heart of any HIV-prevention program. The ultimate message must be: *Your health and potential are important, and you are worth preserving and protecting.* Some aspects of campus life do not promote durable self-esteem, and many students arrive at college without a strong sense of worth. Self-esteem is a special need—and its absence is a particular problem for minority students and for gay, lesbian, and bisexual students.

Underserved Campus Populations

On any campus, populations with special needs in AIDS education exist. Although many observers believe that gay men already must know about HIV infection, it is important to remember that campus populations renew themselves; each year brings new students, some of whom are gay or bisexual. Many institutions

have not provided educational outreach to gay, lesbian, or bisexual students for philosophical, religious, or "public relations" reasons. Even constructive outreach to the gay community will not administer to all the needs, though; many people who have sex with others of the same gender do not self-identify as gay, lesbian, or bisexual and might not seek access to materials or programs for gay, lesbian, or bisexual students.

Students in racial and ethnic minority groups might be missed by AIDS-education programs that aim only at the "average" white student. Great sensitivity is important in designing programs that promote good sexual health for people from racial or ethnic minority backgrounds. International students represent a rich diversity of cultures; AIDS education tailored to American students might seem irrelevant or offensive to international students. Nontraditional or returning students might feel uncomfortable in health-education programs directed primarily at students in late adolescence who live in residence halls.

Financial and Nonfinancial Costs

The complex, integrated educational programs that will succeed in changing behavior will be costly. Educators, materials, programs, and evaluations will utilize resources; counseling and antibody-testing services will be expensive. Professional staff of the clinical and social services for HIV-infected students will require training, continuing education, and support. Self-insured universities will find that HIV-related costs influence their insurance rates and must plan management accordingly. Student health-insurance prices and premiums for employee-benefit packages will rise as well.

Many of the costs will be nonfinancial. AIDS-education programs usually are controversial; the media often is interested in the responses to the presence of HIV/AIDS on a campus. Some alumni and donors will be unhappy with the content or format of programs that promote good sexual health. Community members might be offended or alarmed by condom vending machines, safe-sex pamphlets, or other sexual-health education activities on the campus.

Because AIDS-education programs inherently address sexual behavior and needle use, volatile and emotional points in the beliefs and attitudes of people often will be touched. It is unlikely that any AIDS-education effort that effectively discusses the realities of behavior and suggests options for reducing risk will escape criticism. Some institutions will find the resulting controversy more threatening than will others, but all should be aware of the potential for lively discussion and debate.

Elements of a Campus Response

Education

Colleges and universities must address prevention and service needs, anticipate costs, and manage controversy. Uncertainty and discomfort cannot become apathy or resistance in addressing sensitive topics. Education programs should reach students at all levels; institutions, as employers, should make AIDS education available for faculty and staff as well.

Programs must address the needs of people of any age, race, ethnicity, gender, ability, and sexual orientation. Because no actual HIV-related safety risks are created in the routine academic, workplace, recreational, or residential setting, effective education programs are the best way for an institution to ensure students and employees are safe and healthy.

Policies

Policies are less important than prevention programs. Nonetheless, institutions will profit by instituting statements concerning what they will do, what they will not do, and how they will respond to the challenges of HIV infection. Excessive detail is counterproductive and limiting. Policies ideally provide a general framework within which individual decisions are made on an ad hoc basis. The American College Health Association has developed model guidelines for institutional policy; these are included in the appendix.

Service and Care Programs

Many of the challenges in this decade will involve service and care programs. Colleges and universities will need to find ways to provide counseling and access to HIV-antibody testing for students concerned about HIV infection, as well as resources and personnel to provide services to people with HIV disease. Using the unique characteristics of the college health-care delivery model that emphasizes health promotion and a "low tech, high touch" style, the community of higher education has the opportunity to develop, evaluate, and refine care models that might become broadly applicable in other contexts as well.

To face the needs of faculty or staff who in some way are concerned about and affected by HIV infection, colleges and universities, in their role as employers, likely will need not only personnel policies, but also guidelines for the protection of clinical and laboratory employees whose professional activities might place them at risk for HIV infection.

Institutions also will need to offer counseling or employee-assistance programs to people who are concerned about their own health or the condition of someone close to them, training programs for supervisory and management staff to prepare them to handle HIV-related workplace issues in a sensitive and constructive manner, and education programs for faculty and staff to heighten awareness, to reduce the likelihood of destructive reactions to a coworker or student known to have HIV infection, and to promote a healthy approach to avoiding personal exposure.

CHAPTER 3
Issues and Concerns for Governing Boards

Some colleges and universities have begun to respond effectively to the epidemic of HIV infection. More and more now manage, rather than simply react to, the reality that HIV infection and AIDS can occur on any campus. Many governing boards have accepted the challenge of leadership and have recognized the need for accountability.

Each institution faces multiple needs: to prevent people from becoming infected with HIV, to preserve the health of people already infected, to provide compassionate care for all concerned individuals, and to manage the financial and social problems created by the epidemic.

Governing board members appropriately will be interested in the institution's response to the issues of HIV infection and AIDS. The board will be concerned with these general topics:

- overseeing and monitoring the institution's policies and programs for students and employees;
- managing the institution's resources and periodically analyzing the potential impact of HIV infection;
- evaluating the institution's role as resource, partner, and leader; and
- determining positions on the controversial and complex social and ethical issues linked to the epidemic.

Monitoring Policies and Programs

The epidemic of HIV infection creates certain important responsibilities for colleges and universities in their relationships with students and employees. The governing board will be interested in campus administrators' analysis of these responsibilities and in the steps taken to address the responsibilities effectively. As knowledge about HIV infection increases and the "state of the art" in campus programming evolves, a board will require periodic reports on the nature and efficacy of the campus response.

Institutional Policy

No single universally applicable model is available for AIDS-related policies in higher education. In the early years of the epidemic, it was common for institutions to develop extremely detailed, lengthy, algorithmic policy statements that carefully defined each step and consequence in their management of a student or employee with AIDS. Over time, these policies largely have lain unused, for several

reasons. Many of the issues addressed in freestanding AIDS policies are, in fact, already addressed in a more general sense in other existing policies governing the institution's response to students or employees with other health concerns, infectious diseases, or conduct and behavior problems.

The first five years' experience has revealed few serious problems requiring administrative intervention. State and federal law and agency regulations have identified people with HIV infection as handicapped individuals. As a result, they are eligible for certain protections under law and accommodation in their workplace.

Newer policies usually are much shorter and simpler than their predecessors. An institution's policy rightly states what the institution will do, what it will not do, and what it considers important in responding to HIV infection. A good policy identifies education as the primary priority; it affirms the institution's commitment to compassionate attitudes and caring responses to students or employees with HIV infection.

Depending on what protocols already are in place in other policy texts, little or no addition might be necessary. Many institutions simply have chosen to state that they endorse and will, in general, abide by the policies suggested by the American College Health Association in its "General Statement on Institutional Response to AIDS," which is included as an appendix to this text.

A major concern in policy is the potential risk of HIV infection for students of health-care professions as well as health-care workers and biomedical-research workers who might be exposed to the blood or body fluids of patients, human research subjects, or research animals infected with HIV. The Centers for Disease Control (CDC) and the Occupational Health and Safety Administration (OSHA) periodically have issued statements containing specific recommendations for the protection of these students and workers.

Every institution that teaches or employs people who fall into any of these categories should institute policies that mandate appropriate measures to protect these individuals. Policies also should explain the institution's responsibility in the event of accidents. An evolving challenge for institutions with students and employees in health-care professions is to develop and implement policies governing the work or study of employees or students who themselves are HIV infected and are required to care for patients.

Some institutions employ personal-service workers, such as barbers, beauticians, and manicurists, whose practice should be governed by certain recommendations from CDC and OSHA, as well. Although the risk of acquiring HIV infection in these settings purely is theoretical, and there has been no actual case documenting the acquisition by a personal-service worker of HIV from a client as a result of an occupational accident, it is important as a matter of policy that all institutions comply with CDC's recommendations and OSHA's standards.

The governing board, in reviewing and examining any proposed policy, will be concerned about any provisions that vary significantly from the national standard provided by the "General Statement" or the periodic recommendations of CDC, especially if a submitted policy includes language that might yield to discrimination against HIV-infected students or employees.

The board might believe that no policy at all is required if other existing policies cover the important issues, effective educational programs are under way, appropriate services are provided, the institution does not teach or employ students or workers of health-care professions, and neither the tone nor practice of the administration suggests discrimination. A simply constructed policy, however, provides the institution an opportunity to confirm its concern about preventing further spread of HIV, as well as the institution's intent to model a compassionate and helpful response to HIV-infected people.

The Institution and its Students

In its relationship with its students, an institution properly will be concerned with education and prevention programs, student and social services, and protection against accidental HIV infection in certain contexts.

■ **Education and Prevention Programs.** The primary responsibility of colleges and universities to their students in addressing HIV disease is to provide effective prevention programs. Given the absence of any realistic risk of HIV infection through ordinary interpersonal contact in an academic, residential, or recreational context, providing educational programs is the best way for an institution to ensure their students and employees are safe.

If an AIDS-education program does not exist on campus, the governing board should mandate that one be developed. If such a program is in place, the board should be interested in its characteristics, effectiveness, costs, evaluation, and future development. AIDS-education programs vary extensively from campus to campus, and different strategies work with different student populations. A board's main interest will be in seeing that the campus program fits the needs of the institution's students and addresses the full spectrum of issues.

Without evaluating each program element closely, the board can assay the appropriateness and effectiveness of the educational efforts by asking questions such as these:

1. What is the conceptual basis of the program? An effective program for college and university students clearly is based on the developmental realities of the particular student population. As such, an effective program does not simply provide information about HIV and AIDS. It addresses risks, behaviors, and skill-building. The program should tailor the content and format of its messages to the demographic and educational profile of the institution's students.

2. Is the program comprehensive? Effective programs educate about HIV and AIDS in the context of other health risks to students, such as sexually transmitted diseases, alcohol and drugs, steroid injections, acquaintance rape, and sexual assault.

3. Is AIDS education accessible and available to all students? Effective programs must be available to all students; accordingly, for example, a commuter campus offers programs at a variety of times when different groups of the student population attend classes. Availability also might require repetitive programming which, in turn, creates a challenge to educators to discover innovative strategies to keep programs interesting and "alive." AIDS education should be accessible to everyone—including students who have physical handicaps, different learning

styles, and limited time. Specific outreach programs for racial and ethnic minority students; international students; and gay, lesbian, and bisexual students are all important.

4. What is the role of students in AIDS education? Especially in undergraduate colleges, peer-education programs in which students are trained and guided in providing AIDS education for their peers have been popular and effective. Student input is important in program development, implementation, and evaluation, because students know their peers and their domain well enough to assist faculty and staff in making the program relevant, attractive, and successful. On the other hand, students need guidance, and peer-education programs should include mechanisms for reliable quality assurance.

5. How is the program integrated into the life of the institution? Effective programs require multiple messages from many sources. Consequently, an effective program should not stand in isolation from the academic, recreational, and residential life of students. Programs are properly integrated widely into campus life; AIDS education certainly is the province of the residence-life program, athletic trainers, counselors, women's studies office, international-student program, and minority-student services, as well as the health service.

An effective program integrates health-promotion information into the academic curriculum, using opportunities to explore the personal, psychological, social, ethical, statistical, biological, and historical significance of HIV. Ideally, academic courses include information and assign projects that address AIDS; athletic trainers and coaches participate in educating student athletes; and residence-hall programming includes AIDS education. If students receive AIDS education through many channels, they do not have to choose to attend specific health-education programs.

6. How is the program evaluated? What measures have been taken to ensure quality? An effective program includes evaluation of student satisfaction and outcomes, periodically is compared with regional and national models and standards, regularly is updated, and benefits from current literature and experience in college health and health education.

7. Is the program consistent with the values of the institution? Ensuring that an AIDS-education effort is consistent with the institution's values does not mean that the scope of the program or its content should be constricted. Nonetheless, the governing board, if it is clear about the institution's values, appropriately might seek assurance that the education program reflects respect for those values. Values do not narrow, limit, or change information; values do not alter the facts about prevention of HIV infection. But values might influence the tone and "flavor" of programs.

As the governing board evaluates an institution's program, it will profit from the opinions and perspectives of students, both as the transmitters and as the receivers of education. Although the board also might benefit from hearing the opinions of citizens, alumni, and other interested parties, it is well advised to evaluate all such assessments within the overall context of program effectiveness; it is more important that the program promotes the health of students, rather than suits observers.

Protection from Accidental Exposure

The possibility of accidental exposure to HIV primarily (but not exclusively) concerns students of health-care professions and biomedical research. The governing board will want to know that these students have been informed about the risks of HIV infection, educated about reasonable precautions, and supplied with appropriate equipment and materials for protection. All of these procedures should be implemented in accordance with policies developed and should be consistent with guidelines released by CDC and OSHA.

Potential exists in teaching laboratories in the biological sciences for accidental exposure to HIV if students are required to handle or process the blood of other students. The ACHA "General Statement" recommends that no student (except those in the health-care professions) be required to obtain, handle, or process blood from other students.

Finally, the board will be interested in knowing what procedure the institution intends to follow if accidental exposure to HIV results in a student being infected.

HIV-Related Services

Colleges and universities vary greatly in their approach to providing services to their students. In general, an institution's HIV/AIDS-related services should parallel in concept and structure those services it provides in other areas. For example, a college that operates a comprehensive student-health program that provides a wide array of clinical services should offer care for students with HIV infection as well; if the health service manages chronic illness of other types, it should manage HIV disease, too.

This principle of parallelism in services might require that health-care providers update their knowledge and skills in preparation to manage students with HIV disease or that the health service develop referral arrangements with other care providers in the community to ensure that students with HIV disease receive appropriate evaluation and intervention.

On the other hand, many urban commuter campuses offer a different menu of student services that might concentrate on advising and career counseling rather than personal development and health issues; some institutions have no student-health program of any kind. Although clinical services for HIV disease would not fit comfortably into such institutions' spectrum of student-support services, these institutions still have other service responsibilities to students concerned about or infected with HIV, as noted further in the text.

HIV-Antibody Testing

Anyone, including all college and university students, should have access to safe HIV-antibody testing. Regardless of whether it operates a clinical-health program, any higher education institution should be able to identify local sources of HIV-antibody testing to concerned students. Because of the possibility of early intervention in HIV infection, which could prevent or delay serious complications, people who desire testing should not encounter any administrative barriers. A governing board's interest in its students' health will lead it to seek assurance that referral for HIV-antibody testing is available.

When an institution operates a clinical-health program, it faces an administrative decision about offering HIV-antibody testing as an on-site service. The issues involved are complex: They concern, again, the scope of other services provided, the availability of convenient testing sites, confidentiality of information, state requirements and restrictions, and resources in the health service.

HIV-antibody testing is a complicated service that must involve extensive counseling and support benefits before and after testing is conducted. Even health services that have the laboratory capability to provide the tests might not have the counseling capability to support students in the process.

Although many student-health services now offer confidential or anonymous HIV-antibody testing services, they have experienced risks and benefits. If such a program exists, the governing board should be concerned with several major issues: quality assurance in counseling and in the testing procedure, adequate pretest and posttest counseling, and confidentiality of information.

Clinical Services

Governing board members should be concerned that students are guaranteed access to the same level of care for HIV-related health issues as are students with other health concerns. Concurrently, the board must be satisfied that the high quality of these services is ensured. When clinical services for students include any "invasive" procedures, including venipuncture, blood testing, and minor surgery, the health service should comply with CDC and OSHA recommendations and regulations for a safe workplace.

Psychological Services

Psychological services for students concerned about themselves or others in relation to HIV infection are important components of a comprehensive campus response. Regardless of whether clinical health services are provided, many institutions offer personal counseling for students; again, under the principle of parallelism, such counseling services should extend to the HIV/AIDS-related concerns as well. If an institution provides no personal-counseling services, it still can assist concerned students by offering referrals to community-counseling or mental-health services.

The spectrum of psychological concerns is large and varied and includes, for example:

- the possibility of HIV infection and related issues of behavior and antibody testing;
- knowledge of HIV infection, with concern about future health, academic programs, and careers;
- known or suspected HIV infection in a friend or relative on campus or back home;
- concerns about others who depend on a student who has HIV infection (for example, the children of a woman who has HIV and is the sole supporter of her dependents);
- issues of intimacy, sexual decision making, relationships, and self-determination; and
- concerns about sexual assault.

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Different institutions organize their resources in a variety of ways to address such issues. Governing board members will want to know that the resulting programs are of high quality, that they are easily accessible to students, and that referral to other community agencies is possible when the institution does not offer a needed service.

Disability Needs

Students with HIV disease might, from time to time, require special accommodations because of temporary or permanent disability. On most campuses, these needs are addressed through offices and programs directed toward the needs of students who have other handicapping conditions. Once again, the principle of parallelism of services requires that students with HIV disease receive the same level of appropriate service as do students with, for example, learning disabilities or quadriplegia.

Governing board members will want to know that these services are delivered competently and sensitively to all students who need them.

Social Services

Few higher education institutions provide traditional social services for their students, such as offering access to entitlement programs, locating financial resources to pay for health care, placement in long-term care facilities, and food or housing assistance. For students with HIV disease, certain "social service" needs might arise that require, at least, some familiarity among student-services personnel with community social services and resources. For example, a student with HIV infection might have only limited personal financial resources and inadequate health insurance to cover the cost of zidovudine therapy; a social-service agency might facilitate the process of qualifying him or her for state-assistance programs.

The institution's officers should be able to provide a helpful answer to the question, "What would you do for a student who has HIV disease but can't pay for medications?" Because comprehensive HIV-disease therapies might offer much longer survival and a better quality of life for infected people, it is not appropriate for an institution simply to ignore these needs.

The Institution and its Employees

Colleges and universities, in their role as employers, face certain responsibilities and obligations in connection with HIV/AIDS. In addition, they retain real opportunities beyond the programs and responses mandated in statutes and regulations. Workplace policies might be important, especially when the institution operates health-care or research facilities. Besides policy matters, the areas of concern for employees mirror those addressed for students: education and prevention programs, protection from accidental exposure, and HIV/AIDS-related services.

■ **Workplace Policies.** General policy issues previously have been addressed, but when discussing workplace policies, certain special concerns deserve brief note. Each institution, for example, should address the question of workplace accommodation. To what extent will the institution allow employees with symp-

tomatic HIV disease to alter work schedules, assignments, or settings? Will other employees be permitted to donate sick or leave time?

Another concern might be considered public information or public relations: How will the institution's officers respond to inquiries about its policies and experiences in addressing HIV/AIDS in the workplace?

■ **Education and Prevention Programs.** Any employer holds some important motives to educate employees about HIV and AIDS. Quite separate from any interest in the personal welfare or future health of employees, an employer clearly is interested in preparing employees to reckon with the workplace issues of HIV disease. An educated work force is less likely to yield negative reactions and to propose destructive and discriminatory solutions when HIV-related issues arise.

For example, if the residence-hall maintenance and custodial staff learn the facts about the transmission of HIV in an effective and sensitive way, they probably will not overreact to the presence of a student with HIV disease in campus housing. An uneducated, unprepared staff, on the other hand, might respond emotionally and insist on unreasonable and unnecessary institutional actions for "protection."

One way an institution can reduce the administrative risks associated with HIV disease is through staff-education programs. The focus of these programs will be different from that in educational activities for students, of course; just as the context and meaning in student education is derived from the developmental realities of the audience for which the programs are intended, the same is true of employee programs. The staff probably represents a considerable mixture of age groups, gender, sexual orientation, marital status, and life experience. The most pertinent common interest among staff members about HIV infection lies in the questions surrounding the potential for workplace transmission and the response to the presence and needs of a fellow employee stricken with HIV disease.

Faculty members might profit from AIDS education as well. Although health educators commonly are disappointed at the faculty's reaction to programs, an institution serves well both its faculty and itself by offering faculty-specific AIDS-education services. Members of the faculty, if unprepared for the challenges and issues of HIV/AIDS, might react with unproductive and unhealthy responses. On the other hand, a well-educated faculty can be a meaningful adjunct to campus AIDS-education programs and an excellent source of information and referral for students.

A specific part of the educational mission for faculty and staff involves informing members about the occupational risks of HIV infection. These education programs, when combined with workplace policies that emphasize CDC and OSHA recommendations and adequate protective equipment, constitute an institution's best response to concerns about workplace safety.

Many colleges and universities provide health-promotion or "wellness" programs for faculty and staff. These activities address personal, rather than professional, risks of HIV infection. Scheduling release time from work so employees are able to attend these sessions will convince employees that the institution considers the threat of HIV disease serious and guarantees a larger, more receptive audience.

Instituting AIDS-education programs for employees requires leadership. Too many colleges and universities have chosen not to "rock the boat" by addressing

controversial or sensitive issues. Nevertheless, governing board members reasonably can ask that AIDS-education programs for faculty and staff are implemented and evaluated.

■ **Protection from Accidental Exposure.** An institution's need to maintain a safe workplace requires the development of three elements of a program:

1. a policy and guidelines consistent with CDC and OSHA regulations;
2. an educational progam that prepares clinical and biomedical-research personnel to utilize recommended precautions in the work setting; and
3. adequate and easily accessible supplies of protective materials such as rubber gloves and goggles.

Using regulatory authority, OSHA has issued guidelines that promote safety in the workplace. Any institution receiving federal funding in any of its programs will be expected to comply with current recommendations.

The governing board should be assured that appropriate steps have been taken to control the risk of HIV infection in the workplace.

■ **Employee Services.** Higher education institutions, like other employers, vary greatly in their approach to employee assistance and service programs. Therefore, it is likely that HIV-related services will vary as well. The same principle of parallelism that helps define the nature and extent of student services can be applied helpfully to employee programs: If the institution provides employee-assistance programs in alcohol and drug abuse, personal counseling, family problems, or workplace conflicts, the same level of HIV-related services should be provided.

Employees might report concern about HIV for many reasons. The fears of employees who are working alongside an HIV-infected employee might be productively addressed in an assistance program. Such programs also can be helpful in improving job performance or attendance for those employees. Similarly, an employee who is concerned about a family member or friend who has HIV infection might benefit from counsel. Finally, an employee who has HIV infection might seek employee counselors for help in adjusting to the reactions and attitudes of others.

Institutions also might choose to provide referral services for employees who need information about HIV-antibody testing, psychological assistance, medical evaluation, or legal services.

Prudent Management of Resources

The issues of HIV infection and AIDS might create financial and nonfinancial costs for all colleges and universities. The governing board, in its effort to preserve the institution as a resource for the future, appropriately will monitor those costs and institute procedures and systems for control. The board also should be concerned about any legal risks the institution might face in responding to HIV/AIDS.

Financial Costs

The financial costs of responding to HIV/AIDS on campus include the following:

1. Educational programs. Part or all of the salaries of health educators, counselors, and occupational-health personnel; brochures, pamphlets, and video-

tapes; support personnel and supplies; and professional-development costs for personnel all are considerations.

2. Fringe benefits. Premiums for employee health, life, and disability insurance might be affected by the national and regional experience with the health-care costs of HIV/AIDS.

3. Employee and student protection. Compliance with CDC and OSHA standards for the workplace could result in considerable costs for institutions that operate health-care or research units. In hospitals and clinics, for example, "universal precautions" will require extensive supplies of rubber gloves, masks and gowns, and waste-disposal equipment. These latter costs will be borne by all student-health activities that provide any kind of clinical services, as well.

In assessing any of these costs, members of the board should seek evidence of effectiveness, including conducting comparisons with the experiences of peer institutions.

Nonfinancial Costs

Colleges and universities might incur costs related to HIV/AIDS that are difficult to measure accurately in dollars. It is impossible adequately to assess the value of the loss of colleagues, students, and alumni who have contributed to the life of the campus. How does an institution compensate for the death of an inspired teacher whose creative-writing classes left a mark on a generation of students? How can a college know what a young faculty member would have contributed over many years of research, writing, and teaching?

Some of the nonfinancial costs borne by colleges and universities might, sooner or later, extend to financial implications. The most important of these considerations is the institution's image and public-relations posture.

■ **Image and Controversy.** A governing board prudently is concerned about creating and preserving a "positive image" for the institution, because perceptions of the school might influence support, faculty recruiting, student interest, and alumni loyalty. Concurrently, the board is responsible for protecting the health of its students and employees. In the case of HIV/AIDS and, in fact, perhaps with regard to general sexual-health issues, a board initially might believe that these goals conflict.

Concern about institutional image has provoked helpful and destructive responses. In the early years of the AIDS epidemic, for example, it was not uncommon for college and university officials to believe that they should not be concerned about AIDS and, especially, that they should not institute educational programs. A shortsighted assessment that college students were unlikely to be at risk for HIV infection and hesitancy about addressing issues of sexual behavior further underscored this belief.

On the other hand, many institutions sought to emphasize their commitment to the health and well-being of their students and employees by drawing attention to their AIDS-education programs. Many institutions instituted small-scale education or service programs quietly, perhaps hoping to avoid notice and controversy.

Members of governing boards and institutional administrators frequently have harbored uncertainties and fears about the propriety of AIDS education or the

reactions to programs promoting good sexual-health practices. These fears included the possibility of negative media coverage; the potential loss of trustee, alumni, or donor support; the threat of antagonism or strain in relations with community leaders; and a decrease in applications for admission or acceptances of offers.

In colleges and universities with religious affiliation or governance, there often has been concern about perceived conflicts between an AIDS-education program and the values or principles inherent in the religious doctrine. In all of these situations, the governing board has feared some costly consequence of dealing with HIV/AIDS. These fears are not entirely unrealistic, but they must be balanced against the potential consequences of inaction.

AIDS-education and service programs are, in fact, likely to be controversial. The HIV-infection epidemic has raised a multitude of vexing social questions; therefore a governing board can expect a spectrum of opinions about campus AIDS programming. The more effective and successful programs almost inevitably will foster controversy. Many parents and alumni, for example, would prefer that college students remain sexually inactive; they might believe that AIDS-education programs somehow promote sexual behavior. Similarly, condom distribution or vending services might alarm some observers while reassuring others.

People probably will charge that explicit, targeted programs that promote good sexual health use offensive language. People who have strong negative views about homosexuality might criticize AIDS-education programs—programs that actually build the self-esteem of all students of any sexual orientation. Religious leaders might declare that the campus AIDS-education program violates family or religious values. It is quite likely, in fact, that within the diversity of a governing board, some members will share many of these viewpoints; therefore, controversy might exist not only between the board and its various constituencies, but also within the board itself.

Certain institutions will face special challenges. State laws and policies might limit the flexibility of the responses of some colleges and universities. Institutions with religious affiliation or governance might incur wrath by any action that seems inconsistent with doctrine or, alternatively, by failing to take such action.

The cost of controversy will be determined by the management of disagreement. Controversy actually might promote HIV/AIDS awareness and serve to highlight the institution's commitment to protecting its students. A college or university is, certainly, a place of ideas and debate; no institution should fear retribution for the free expression of opinion. It is productive for governing board members to listen with respect and interest to a variety of perspectives; often, people expect agreement less than they expect a fair and considerate hearing.

Once the board has gained a clear sense of its own values and views, it must not allow the potential for controversy to prevent forthright speech. The board should be prepared to defend its position and choices and to act from a point of leadership and vision. It will not be effective to seek to avoid controversy by simply "giving in" to the most vocal, vociferous, wealthy, or powerful critic of institutional policy and programs. Many institutional officers mistakenly have assumed that the loudest voices represent the majority constituency.

The board will be concerned about the mechanisms by which the institution's administrators plan to manage the public-relations aspect of their AIDS-related programming. A carefully developed plan to address media inquiries, parents' questions, community reactions, and the spectrum of opinion within the institution itself is important. Selecting a spokesperson from the administration or faculty and referring all questions to that individual is an effective strategy to limit the scope of public controversy.

■ **Information About Students or Employees with HIV Infection.** Special sensitivity surrounding the institution's image might exist with regard to the on-campus presence of HIV-infected students or employees or the prevalence of HIV in the campus population. Administrators, board members, or alumni might worry that the institution will lose status, prestige, applicants, or funds if students or employees that have HIV disease are revealed.

Especially in these times of enrollment competition, institutional officials might be concerned that parents or high school guidance counselors will steer prospective students elsewhere. Administrators at some colleges have refused to participate in research studies designed to measure the rate of HIV infection among students, because they feared the consequences of discovering that their "rate" was higher than that at some other campus. When other issues create controversy on a campus, there might be great reluctance to risk further disclosure.

Many of these fears easily are understood, because public sophistication about HIV infection and AIDS still is limited. Nonetheless, colleges and universities also accept a responsibility to uphold truth—even when truth creates discomfort or is disquieting. As the unhappy reality of campus HIV infection becomes clearer across the nation, the risk of disclosing its presence in any specific population will continue to decrease. Institutions that acknowledge and address the risks of HIV infection for their students will appear more caring and responsible. Attempting to pretend that any institution is "immune" to HIV is both absurd and shortsighted.

■ **Legal Liability.** A detailed analysis of legal issues in higher education related to HIV/AIDS is beyond the scope of this report, but a few general points bear emphasizing:

1. An institution's duty to maintain a healthy and safe environment for students is best addressed by implementing effective AIDS-education programs. Although it ostensibly would be difficult for a plaintiff to prevail in a court of law, it is possible that an institution that did not provide AIDS education could be sued in the event that an "uneducated" student contracted HIV infection. Conversely, it is difficult to perceive a situation in which a college or university would be liable because accurate HIV/AIDS information and education was provided to students.

2. All institutions are expected to conform to workplace-safety regulations and procedures. Failure to comply might result in agency action, jeopardy to research and other government funding, legal liability for harm to employees, and organized or informal employee protests.

3. Any student or employee discrimination due to HIV infection can create legal liability. Similarly, failure to accommodate the handicaps of persons with HIV disease will place institutions in violation of federal and/or state statutes.

4. The accidental or willful compromise of confidential medical information about HIV infection or AIDS also might invite legal liability. Many states maintain specific statutes that provide penalties for disclosing medical information without the specific consent of the person involved except in closely defined situations. No institution should maintain policies or requirements that violate the letter or spirit of these statutes.

Any policy that allows or mandates disclosing the identity of a student or employee with HIV disease should be examined and reevaluated. Similarly, any formal or informal policy that could impair the safety of confidential information should be reexamined and revised—for example, employing students in health or counseling centers where they might have access to the confidential records of other students.

If the governing board is assured that the institution's policies and programs are reasonable, there should be no serious concern about incurring legal liability. If reason for concern about legal exposure exists, the concern should be focused on the policies and programs.

The Institution as Resource, Partner, and Leader

■ **Resource.** Colleges and universities often attempt to serve as resources to their communities. Some institutions seek a wider role, seeing themselves as resources for a state, the nation, or the world. In this capacity, campuses become centers of culture, places of debate and discussion, stewards of books and information, purveyors of entertainment, and harbors for research and knowledge. Institutions might adopt a similar role in responding to HIV/AIDS.

The educational programs developed on college campuses, for example, have become models for effective teaching in grades K-12 as well. Health educators on college and university campuses have served as mentors and leaders in developing school and workplace AIDS-education programs. The information needs of communities often are met in the library and human resources of colleges. Academic researchers in natural and social sciences have contributed much to understanding the epidemic and its consequences.

In serving as a resource, an institution accomplishes an important societal duty and assists in advancing its own interests. The "positive image" produced by contributing speakers, materials, space, and thought to a community's response to AIDS is valuable as a college addresses the controversies created by the epidemic.

■ **Partner.** A governing board appropriately will expect the institution to cooperate with other agencies to respond effectively to HIV/AIDS. A few examples illustrate this point:

1. Any college or university can work with other higher education institutions to share resources, reduce costs, extend influence, and manage controversy. A small college, for example, might not be able to afford its own health educator; it might, however, share other resources, such as space or training costs, with neighboring institutions to help develop a mutually beneficial AIDS-education program. The services of a speaker brought in by one school can be shared with another campus.

2. It might be easier and more efficient if a large university that desires to provide HIV-antibody testing services cooperates with the state health department to establish a "branch" state testing site in the college health center.

3. Several colleges in a city or region might apply together for funds earmarked for innovative AIDS-education programs or epidemiologic surveillance.

4. A college might cooperate with the local community-based AIDS-service organization to develop an AIDS-education program for residence-hall staff or college faculty. In return for the time and skills of the agency's educators, the college might agree to allow the organization to use college facilities for some of its other educational programs.

5. An institution might participate in regional or national research studies designed to investigate the behavioral risks of HIV infection among students, the prevalence of infection, or student knowledge and attitudes about AIDS.

■ **Leader.** Because the epidemic of HIV infection falls squarely at the turbulent intersection of medical and social issues, it has generated enormous controversy. By forcing attention to issues, people, and needs long ignored or overlooked, AIDS has created social discomfort and demanded social change. In its connections to sex, illness, drugs, and death, HIV confronts our society with subjects that have been taboo, words that have not been used in "polite" conversation, and civic realities that many people never have considered. The circumstances of epidemiology that resulted in high rates of HIV infection among gay and bisexual men and intravenous-drug users have stirred sharp controversy. Accusations of guilt and protestations of innocence coexist with allegations of immorality and charges of moralism.

The risks and controversies that surround AIDS in our society challenge institutions of higher education with the need for leadership. Colleges and universities are expected not just to respond to needs, but to model an effective and compassionate example. By developing a sound vision and a clear sense of values and priorities, campus officials can become leaders. A university teaching hospital, for example, might present a model of compassionate care in serving people with HIV disease and, in doing so, promote better assistance in other health-care facilities in the community. Teachers and clinicians in academic positions might be recognized for their contributions to AIDS education and services. A church-related college might develop an innovative AIDS-education program that is both clearly rooted in the church's values and is relevant to the behavioral context of its students.

The Board as Citizen: Taking Positions

The specific social and political issues surrounding the HIV epidemic are examples of difficult questions that our country and our higher education institutions face. In general, the principle of institutional neutrality governs the response of governing boards to demands that they take positions on controversial issues; the same principle applies to the political questions regarding AIDS.

There might be, for example, demands that a governing board denounce proposals for more or less funding for AIDS research, relinquish investments in drug companies that charge extremely high prices for pharmaceuticals used to

treat HIV infection, or issue statements criticizing government officials or their decisions. In approaching these requests, a board is well advised to apply guidelines similar to those it would use in addressing any other social or political issue.

In general, such an approach will signify that the board will encourage discussion, provide the opportunity to express different points of view, and encourage its officers, employees, and faculty to speak and act as individuals rather than as representatives of the institution. [For more information on this subject, see the AGB Special Report, "The Board's Role in Dealing With Social and Political Issues."]

If an institution has a clear vision of its priorities in responding to HIV/AIDS and chooses to demonstrate leadership by developing sound policies and programs, its actions will speak of reasonability and compassion. Taking formal public positions and issuing statements about controversial issues will add little to this posture and might damage the institution's credibility and flexibility.

It is unlikely that any government or agency would propose to attend to people with HIV disease in a way that is threatening to the basic independence and academic freedom of a college or university. However, if such a situation developed, a governing board appropriately would discard its neutral stance to protect its own future and best interests.

CHAPTER 4
Guidelines for a Board's Response

Because all governing boards are different, the style, format, and content of a board's response to HIV/AIDS will vary. The previous chapter suggests the most pressing issues demanding a board's consideration and attention; this chapter summarizes some of those concerns into specific recommendations and offers guidelines that might be useful in a board's deliberations.

These recommendations and guidelines should be interpreted and applied within the distinctive context of each institution or system. Such factors as the capabilities of college officers, the "tone" of the relationship between the board and those officers, the social and political climate in the community, and the degree of managerial activism characteristic of the board will influence how your board acts.

First Steps: Preparation

The members of many boards have discovered that presentations about HIV disease are useful in preparing to address the campus issues. Physicians or other health professionals serve as members of many boards; they might help their colleagues develop a sound base of knowledge and ensure it remains current and relevant. Members of the student-affairs professional staff might deepen the board's background in student-development theory and practice, point out the implications of the institution's student population, and advise the board of AIDS-related programming at comparable institutions. Resource materials from professional organizations in higher education, public-health departments, and health educators offer a reference point for decision making.

The Board in Action: Recommended Guidelines

Monitoring Policies and Programs

A. General Guidelines

1. Define a mechanism by which the board will receive periodic reports and analyses about HIV/AIDS-related issues on campus. Identify an institutional officer responsible for compiling and providing these reports.

2. Define the extent and character of the board's participation in decisions about programs and policies. For example, if a campus task force exists, does a member of the board participate? What kinds of policy or program decisions will require board review?

B. Policies

1. Require an analysis of existing institutional policies for students and employees to determine what areas, if any, demand specific attention in an HIV/AIDS policy.

2. Seek assurance that any existing campus HIV/AIDS policy generally conforms to guidelines suggested by the American College Health Association.

3. Seek assurance that policies comply with requirements and guidelines issued by CDC and OSHA, as well as with any relevant local or state health and regulatory authorities.

4. Seek assurance that no policy provisions violate state or federal statutes governing discrimination against people with disabilities and handicapping conditions.

5. Require that any HIV/AIDS policy affirms the institution's commitments to (a) education to prevent the spread of HIV and (b) compassionate attention to the needs of people affected by HIV.

6. Require that any policy be reviewed periodically and revised as needed.

C. Student Concerns and Issues

1. Ask institutional officers to provide an analysis of the demographic characteristics of the student population and the specific needs of the population in AIDS-related education and services.

2. Require the implementation of an effective AIDS-education program that is available and accessible to all students.

3. Evaluate the education program to determine whether:

- it is based on and implemented according to a strong conceptual framework in student-development theory and is consistent with effective models of AIDS education on campus;
- it is comprehensive in addressing the entire spectrum of HIV/AIDS-related issues;
- it is accessible and available to all students (residential, commuter, undergraduate, graduate, disabled, full-time, part-time); likewise, it specifically and sensitively deals with the concerns of students of minority race, women, gay/lesbian/bisexual students, and international students;
- students are involved in designing, implementing, and evaluating the program;
- it is well integrated into campus programming, including the academic curriculum;
- it is periodically evaluated and improved; and
- it acknowledges and addresses the values of the institution.

4. Seek assurance that students are protected through policies, procedures, educational programs, and equipment that reduce the risk of accidental transmission of HIV in laboratory or health-care settings.

5. Require that HIV-related services be provided in an extent and format parallel to those provided for students with other health problems.

6. Seek assurance that any student who desires HIV-antibody testing is offered this service through the campus health service or by referral to agencies in the

community. Require that campus officers, especially in health and counseling services, be aware of local sources of HIV-antibody testing. If HIV-antibody testing is performed as a campus service, require that adequate, competent pretest and posttest counseling be provided as a routine part of the testing process.

7. If the institution offers HIV-antibody testing, seek assurance that the technical aspects of testing, counseling procedures, and precautions for protection of confidential information are of high quality and consistent with the best professional standards.

8. Request information about clinical, counseling, and disability services provided to students concerned about HIV infection, and seek assurance that these services are of high quality.

9. Request periodic reports about the institution's experience in managing students with HIV disease: What gaps in services are identified? How are students coping with the psychological issues? What social services are needed? What is the academic experience of students with HIV infection?

D. Employee Concerns and Issues

1. Review the HIV/AIDS-related components of workplace policies. Approve plans for disability accommodation, workplace safety, protection from discrimination, and employee assistance.

2. Require an appropriate AIDS-education program targeted to the specific needs of various groups of staff and faculty. Especially, seek assurance that employees with clinical or laboratory responsibilities involving the possibility of exposure to HIV are required to attend AIDS-education and accident-prevention programs.

3. Seek assurance that employees who might have workplace exposure to HIV have adequate and easily accessible supplies of protective materials.

4. Request reports on the involvement of faculty in AIDS-education programs for students and for other employees. Consider expressing a boardwide opinion that faculty participation in AIDS education is an appropriate goal.

5. Require that employees be provided with HIV/AIDS-related services to a level parallel with that used to define the extent of services for other health problems; especially, seek assurance that employee-assistance counselors are trained in HIV/AIDS issues and referrals.

Prudent Management of Resources

A. Financial Costs

1. Request reports about the financial commitment of the institution to AIDS-education programs for students and employees.

2. Request information about the financial impact of workplace protection programs; seek information about the impact of HIV/AIDS issues on fringe-benefit plans.

3. Ask for comparisons between costs at your institution and those at neighboring and peer campuses.

4. If the institution operates hospitals, request reports on health-care costs and payments for HIV/AIDS-related clinical visits and admissions; ask that institutional officers project future trends and implications.

B. Nonfinancial Costs

1. Require that the institution designate an officer responsible for handling inquiries and press relations in connection with AIDS.

2. Request reports about HIV/AIDS-related controversies in the campus community; when necessary, state board support for administrators who have adopted appropriate positions and demonstrated leadership.

3. Provide a forum within the board's meetings for discussion of controversial issues related to HIV and AIDS.

4. Provide leadership as the institution's officers develop a plan for managing inquiries about the campus experience with HIV and AIDS.

5. Require that the institution be in full compliance with federal and state guidelines for workplace safety; with local, state, federal, and professional standards regarding protection of confidential information; with state regulatory and reporting requirements for HIV disease; and with any relevant statutes providing protection against discrimination.

The Institution as Resource, Partner, and Leader

A. Resource

1. Request reports about the work of the institution and its officers and faculty on HIV/AIDS-related issues: authorship, research, exemplary teaching, development of model education programs, consulting, testimony for commissions and boards, media appearances, and superior service on campus.

B. Partner

1. Request information about HIV/AIDS programs and policies at neighboring and peer institutions.

2. Encourage administrators and faculty to share resources, personnel, space, and programs with colleagues on nearby campuses.

3. Encourage cooperation among campus officers, faculty, staff, and students as well as local health officials, school administrators, teachers, social-service agencies, and AIDS-support organizations.

4. Support the institution's participation in important regional and national research concerning HIV/AIDS.

C. Leader

1. Recognize and support students, faculty, or staff who have demonstrated leadership in the institution's response to HIV/AIDS.

2. Encourage creative faculty, staff, and students who have developed model programs, policies, or curriculums to share those products with colleagues regionally and nationally through professional conferences, publications, and press contacts.

The Board as Citizen

1. Encourage campus discussion and debate about issues of public policy and social concern related to HIV/AIDS.

2. Remind institutional officers, faculty, staff, and students that they may not take positions on behalf of the institution nor lobby for particular points of view as a representative of the institution, unless specifically authorized to do so.

3. Except in the case of threats to academic freedom or other highly unusual circumstances, maintain institutional neutrality in response to issues of public policy concerning HIV/AIDS.

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APPENDIX

American College Health Association General Statement on Institutional Response to AIDS

Introduction

The American College Health Association (ACHA) presents these recommendations and guidelines for institutions of higher education in response to the epidemic of infection with Human Immunodeficiency Virus (HIV), which causes the Acquired Immune Deficiency Syndrome (AIDS). This statement updates the editions of the *General Statement on Institutional Response to AIDS* issued December 2, 1985 and January 1, 1988. The recommendations and guidelines herein are based on the best currently available medical information and on statements by the United States Public Health Service and the Centers for Disease Control. ACHA has released detailed information and guidelines on certain specific areas of concern to colleges and universities in a special report, *AIDS on the College Campus*. Periodic future statements will update the special report and address other issues as they arise.

Communities in higher education must respond effectively to the epidemic of HIV infection. In a campus environment many students encounter new independence, self-determination, and strong peer pressure to adopt certain behaviors. For some students, an uncertain sense of identity and self-esteem can further complicate decision making. Experimentation with sexual behaviors and/or drug use may put college and university students at a greater risk of infection. Young adults often feel invincible and tend to deny personal risk. Many people in campus communities believe that HIV infection and AIDS are problems faced elsewhere, or are concerns only for "other kinds" of people. The prolonged latency between infection with HIV and the eventual development of "Full-Blown AIDS" will promote the relative invisibility of the infection, an effect which will seem to validate the myth among students (and some faculty and administrators) that "it cannot happen here."

HIV infection is potentially lethal, but absolutely preventable. Each college or university community must do more than be aware of the risks of HIV infection. Each community must accept that HIV infection and AIDS can, in fact, happen on any campus. Every institution of higher education must be accountable to its community to do everything possible to prevent people from being infected, to limit the consequences of established infection, and to provide compassionate care for all concerned individuals. These challenges will demand strong leadership and commitment.

ACHA acknowledges the valuable assistance of the American Council on Education (ACE) in the development of guidelines pertaining to the legal issues and questions presented by the epidemic of HIV infection and appreciates the support of the National Association of Student Personnel Administrators and the Association of College and University Housing Officers-International.

Educational Programs

The primary response of colleges and universities to the epidemic of HIV infection must be education. The American College Health Association recommends that the organization and implementation of effective educational programs about AIDS and HIV infection be an activity of the highest priority for all institutions of higher learning. In designing the format and content of educational programs, it is important to recognize and address the rich diversity of people in the campus community and to provide opportunities for effective learning by people of any age, ability, gender, ethnicity, or sexual orientation.

Because there is as yet neither a vaccine to prevent HIV infection nor curative therapy for persons infected with HIV, the most pressing need for institutions will be to implement programs which increase awareness and provide education to prevent further spread of the virus. Although knowledge about limiting the consequences of established HIV infection is only beginning to develop, it is important that AIDS-education programs also provide what information is available. The following are specific recommendations concerning educational programs.

1. Comprehensive educational programs must address not only undergraduates but also graduate and professional students; they should reach not only residential students but also commuters and nontraditional students. Programs to educate students about HIV infection and AIDS should also be available in junior and community colleges and in all schools offering postsecondary education, including continuing education programs.

2. Colleges and universities should offer similar educational opportunities for institutional employees, faculty, and staff. Providing education to faculty and other employees will require leadership from campus health and personnel officers and commitment from senior administrators.

3. The epidemic of HIV infection raises issues of liability that are of great concern to college and university administrators; currently, the most effective means of addressing these issues is to educate students and employees about HIV infection and AIDS and to take such reasonable precautions as are suggested herein. Educational programs will also be of paramount importance in discharging the institution's responsibility to protect its student body and staff from the transmis-

sion of HIV. As medical evidence consistently indicates that no actual safety risks are created in the usual workplace or academic setting, institutions can best render enrollment or employment safe and healthful through effective education and training programs.

4. The program of education provided by the institution should emphasize the following:

- Even though they may not have symptoms, persons with HIV infection may transmit the virus to others through intimate sexual contact or exposure to blood; a woman with HIV infection may transmit the virus to her child before or during birth or by breast feeding.
- Among people who choose to be sexually active, the consistent and conscientious use of condoms and spermicides containing nonoxynol-9 greatly reduces the chance of transmission of HIV through sexual intercourse.
- The sharing of needles used in the injection of illicit drugs is an efficient way to transmit HIV. It is possible that sharing needles used to inject steroids or for other reasons may transmit HIV as well.
- Persons with documented HIV infection and those with behavioral risk factors for HIV infection should not donate blood, plasma, sperm, or other body organs or tissues.
- People with HIV infection pose no risk of transmitting the virus to others through ordinary, casual interpersonal contact.
- It is possible that certain interventions and therapies may help limit the consequences of HIV infection among people already infected. People who know they have been infected may thus benefit from regular medical follow-up and immunologic evaluation.
- Discrimination against people who have, or are perceived to have, HIV infection is unwarranted, hurtful, and wrong.

5. In colleges and universities with resident students, residence hall staff (both students and employees) should receive education about HIV infection and AIDS prior to the arrival of new students each session.

6. Students should play a major role in designing, implementing, and evaluating educational programs. Peer-education models will be especially effective.

7. As a component of its educational program, an institution should inform students and employees about condoms and spermicides and their proper utilization. Condoms and spermicides should be readily available to all students. Colleges and universities may best accomplish this by vending condoms and spermicides in machines, which allows individuals to obtain these materials anonymously and outside regular business hours. Less effective alternatives to condom vending include distributing or selling condoms and spermicides in the health service or at campus stores and referring students to private retailers.

8. In order for educational programs to be effective, they must provide current information, use reliable, up-to-date materials, and be both easily accessible and widely available. The Task Force on AIDS of the American College Health Association produces and periodically updates educational brochures and videotapes dealing with various aspects of HIV infection and AIDS which are available to all institutions. Detailed recommendations for educational programs, including sug-

gested formats and methodologies, are included in the special report, *AIDS on the College Campus*. ACHA will continue to release new educational material, reports, and programming suggestions.

Recommended Policies

A. Application

These guidelines, which derive from the best currently available medical facts about HIV infection and AIDS, apply to all students or employees with HIV infection. People with HIV infection may be healthy, but have evidence of the infection because of the presence of an antibody to the virus in their blood; others have a condition meeting the criteria of the surveillance definition of AIDS itself, or one of the lesser symptomatic manifestations of infection (such as AIDS-Related Complex or Progressive Generalized Lymphadenopathy).

B. Transmission Information Relative to Policies

Current knowledge indicates that students or employees with any form of HIV infection do not pose a health risk to other students or employees in an academic setting. HIV is transmitted perinatally, by intimate sexual contact, and by exposure to contaminated blood. Although HIV may be found in many body fluids and secretions of people who are infected, its presence is clearly correlated with transmission only in blood, semen, and female genital secretions; breast milk may transmit the virus to a nursing infant. There has been no confirmed case of transmission of HIV by any household, school, or other casual contact. The Public Health Service states that there is *no risk* created by living in the same place as an infected person, eating food handled by an infected person, being coughed or sneezed upon by an infected person, casual kissing, or swimming in a pool with an infected person. See the following statements:

Centers for Disease Control. Education and foster care of children infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus. *Morbidity and Mortality Weekly Reports* 1985; 34:517-521.

Centers for Disease Control. Recommendations for prevention of transmission of infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the workplace. *Morbidity and Mortality Weekly Reports* 1985;34:681-6, 691-6.

Health care workers with clinical responsibilities and certain laboratory technicians have a very small but real risk of HIV infection through direct contact with contaminated blood or laboratory preparations. Most such exposures can be prevented by consistent adherence to established infection-control guidelines.

These facts are the basis for the following guidelines.

C. Guidelines for Institutional Policy

■ **1. General Policies.** The American College Health Association recommends that institutions adopt only general policies, such as are included herein, concerning students or employees with HIV infection. ACHA suggests that institutions respond to each case as required by its particular facts. Given the uncertain legal obligations and challenges involved, institutions are advised neither to devise nor implement inflexible policies.

■ 2. **Institutional Committee.** It is appropriate for college and university officials to designate a group of administrators and faculty to manage the process of evaluating individual cases, to organize and oversee the educational program, and to provide a mechanism for making such policy decisions as become necessary.

■ 3. **Handicapping Conditions.** It is clear that persons with AIDS itself (and, possibly, those with other manifestations of HIV infection) will be considered as having handicapping conditions; in making decisions, college and university officers are advised to guarantee the legal rights of these individuals. Existing support services for people with handicapping conditions can be appropriately and effectively utilized by students or employees disabled by HIV infection.

■ 4. **Admissions.** No institution of higher education should include consideration of the existence of any form of HIV infection in the initial admissions decision for people applying to attend the institution. The exclusion of people with HIV infection for reason of that infection constitutes unwarranted discrimination.

■ 5. **Attendance.** College and university students who have HIV infection, whether they are symptomatic or not, should be allowed regular classroom attendance in an unrestricted manner as long as they physically and mentally are able to attend classes.

■ 6. **Access to Facilities.** There is no justification, medical or otherwise, for restricting the access of persons with HIV infection to student unions, theatres, snack bars, gymnasiums, swimming pools, saunas, recreational facilities, or other common areas.

■ 7. **Residential Housing.** Decisions about housing for students with HIV infection must be made on a case-by-case basis. The best currently available medical information does not indicate any risk to those sharing residence with infected individuals. In some circumstances, however, there may be reasonable concern for the health of students with immune deficiencies (of any origin) when those students might be exposed to certain contagious diseases (for example, measles or chicken pox) in a close living situation. Health officers and administrators in institutions with the flexibility to provide private rooms may wish to protect the health of the immunodeficient student—not to protect other students from them. The American College Health Association recognizes that the fear of HIV infection and AIDS may cause considerable pressure to be brought to bear on housing officers, and has provided a thorough discussion of options in residential housing in the special report, *AIDS on the College Campus*.

■ 8. **Medical Care.** The following recommendations pertain to the provision of clinical services to people with HIV infection.

■ **Medical history.** Institutions of higher education should not routinely ask students to respond to questions about the existence of HIV infection. It is, however, appropriate in many institutions to encourage students with HIV infection to inform campus health care providers to enable the institution to provide them proper medical care, support, counsel, and education. This, like any other medical information, should be handled in a strictly confidential manner in accordance with the procedures and requirements in effect at the institution.

■ **Medical and psychological follow-up.** Clinicians in health services and counseling centers should make provisions for medical, psychological, and support services which promote the best physical and mental health of persons with HIV infection. Institutions should organize these resources *prior* to their need to avoid causing anxiety and distress in individuals requiring assistance. If these services are beyond the scope of comparable services provided on campus, the institution should immediately identify other care providers who will see students by referral.

The evolution of antiviral or immunomodulating therapies for HIV infection requires that campus health care providers be aware of current developments and practices in immunologic evaluation and treatment. If these services are beyond the scope of patient care services offered on campus, health officers should be able to refer students or employees to other facilities.

■ **Contagious diseases.** Special precautions to protect the health of immunologically compromised individuals should be applied during periods of prevalence of certain casually contagious diseases, such as measles and chicken pox.

■ **Immunizations.** Persons known to have HIV infection should receive measles and rubella vaccinations and need not be exempted from institutional requirements for those vaccinations. However, clinicians in health services should be aware of current recommendations for other immunizations in persons with HIV infection because of potentially serious consequences of their receiving live virus vaccines. Some vaccines required for foreign travel may be deleterious to the health of persons infected with HIV.

■ **9. HIV-antibody testing.**

■ **Mandatory testing.** College and university officials should not undertake programs of mandatory testing of either employees or students for antibody to HIV. Mandatory testing programs will be cost-ineffective, counterproductive, and discriminatory.

■ **Voluntary.** College and university health services should be familiar with sources of testing for antibody to HIV and should be able to refer students or employees requesting tests. Health care providers should understand the capabilities and limitations of the test and should be able to counsel and educate persons who seek testing. Administrators and clinicians must be familiar with state and local laws and public-health requirements regarding charting of results, release of confidential information, and reporting of test results.

Whether the tests are performed through the campus health service or not, they should be done if and ONLY if:

1. they can be anonymous, or if anonymous testing is not possible, strictly confidential;

2. positive results on the screening test (ELISA test) are confirmed by another procedure; and

3. both pretest and posttest counseling are a mandated part of the program.

■ **10. Confidentiality of information.** People known or suspected to have HIV infection, whether or not they have symptoms of illness, have sometimes been victims of discrimination and physical or psychological abuse. The potential for discrimination and mistreatment of these individuals, and of persons thought to

be at risk of infection, requires that confidential information concerning any aspect of HIV infection be handled with extraordinary care.

■ **Standards.** Guidelines concerning the handling of confidential material about people with HIV infection follow the general standards included in the American College Health Association's *Recommended Standards and Practices for a College Health Program*, fourth edition:

In general, it is recommended that no specific or detailed information concerning complaints or diagnosis be provided to faculty, administrators, or even parents, without the expressed written consent of the patient in each case. This position with respect to health record is supported by the Family Education Rights and Privacy Act of 1974.

■ **Release of information.** No person, group, agency, insurer, employer, or institution should be provided any medical information of any kind without the prior written consent of the patient. Given the possibility of unintended or accidental compromise of the confidentiality of information, health officers should carefully weigh the importance of including any specific information about the existence of known HIV infection in the ordinary medical record except when circumstances of medical necessity mandate it. At minimum, the inclusion of any information regarding HIV infection in the medical record should be discussed with the patient prior to its entry.

■ **Legal liability.** Health officials and other institutional officers must remember that all confidential medical information is protected by statutes and that any unauthorized disclosure of it may create legal liability. The duty of physicians and other health care providers to protect the confidentiality of information is superseded by the necessity to protect others only in very specific, life-threatening circumstances.

■ **"Need to know."** The number of people in the institution who are aware of the existence and/or identity of students or employees who have an HIV infection should be kept to an absolute minimum, both to protect the confidentiality and privacy of the infected persons and to avoid the generation of unnecessary fear and anxiety among other students and staff. ACHA has released a more detailed statement discussing the handling of confidential information as part of the special report, *AIDS on the College Campus*.

■ **Informing other students or employees.** There is absolutely no medical or other reason for institutions to advise students living in a residence hall of the presence there of students with HIV infection. Similarly, college and university officials should not reveal the identity of students or employees with HIV infection in any other setting. The responsibility to provide a safe living environment is best dealt with by educational programming, as discussed earlier. Sharing confidential information without consent may create liability and lead to harassment or discrimination.

■ **Public-health reporting requirements.** College and university health services must strictly observe public health reporting requirements. In all jurisdictions, cases of AIDS meeting the criteria of the surveillance definition of the Centers for Disease Control must be reported to the local public-health authorities. In a few areas, seropositivity for antibody to HIV is also reportable but must be

kept confidential. The detailed revised surveillance definition for AIDS for case reporting purposes is included in:

Centers for Disease Control. Revision of the CDC surveillance case definition for acquired immunodeficiency syndrome. *Morbidity and Mortality Weekly Reports* 1987;36:1S.

■ **Secondary lists or records.** Neither health officers nor other administrators should keep lists or logs indentifying individuals tested for antibody to HIV or known to be infected with HIV. The potential for compromise of confidential information far exceeds any conceivable benefit of such listings.

■ **11. Safety precautions.** All colleges and universities should adopt safety guidelines as proposed by the United States Public Health Service for the handling of the blood and body fluids of all persons, not just those previously known to have HIV infection. These "universal precautions" are necessary, because many people with HIV infection are not identified in advance. The same procedures should thus be followed for the handling of blood and body fluids of *any* student or employee.

■ **Disinfection.** Surfaces contaminated by blood or other body fluids can be successfully cleaned and disinfected with commercial disinfectant solutions or with household bleach, freshly diluted in a 1:10 solution.

■ **Health care providers.**

1. Public Health Service procedures. In order to prevent the accidental transmission of HIV in health care settings, institutions which operate health services, laboratories, or clinics for students or staff should implement current recommendations from the Public Health Service for infection control and should monitor compliance with these procedures. Colleges and universities should provide educational programs about HIV infection and its transmission in health care settings to all clinical personnel. The following articles provide current recommendations.

Centers for Disease Control. Recommendations for prevention of HIV transmission in health care settings. *Morbidity and Mortality Weekly Reports* 1987; 36:2S.

Centers for Disease Control. Update: Universal precautions for prevention of transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and other bloodborne pathogens in health-care settings. *Morbidity and Mortality Weekly Reports* 1988;37:377-382, 387-388.

Medical and nursing professionals, dentists and oral surgeons, dental hygienists, optometrists, other clinical service providers, and research laboratory technicians handling blood or body fluids should be familiar with recommended infection-control procedures and should follow them consistently.

2. Equipment. College and university health services should use disposable, one-user needles and other equipment whenever such equipment will puncture the skin or mucous membranes of patients. The same safety precautions must be used with all patients. If disposable equipment is not available, any needles or other implements that puncture skin or mucous membranes should be steam sterilized by autoclave before reuse or safely discarded. Extreme caution should be exercised when handling sharp objects, particularly in disposing of needles.

■ **Teaching laboratories.** Colleges and universities should also adopt safety guidelines for the handling of blood and body fluids of all persons in teaching laboratories. Laboratory courses requiring exposure to blood, such as biology courses in which blood is obtained by finger prick for typing or examination, should use disposable equipment, and no lancets or other blood-letting devices should be reused or shared. No students, except those in health care professions schools, should be required to obtain or process the blood of others.

■ **12. Support Services.** The psychosocial consequences of actual or feared HIV infection are such that college and university students and employees may experience enough suffering to impair their health, interfere with academic or work performance, cause extreme psychological distress, disrupt plans, and cripple relationships. Psychological, emotional, and spiritual health may also be important allies for people with established HIV infection. The American College Health Association, therefore, recommends that all institutions develop easily accessible and widely available support services through which concerned persons can receive counseling, assistance in locating and using social resources, and referrals for further assistance. Often, these needs may be met through existing student services or employee-assistance programs or by identifying community-based resources for referrals.

■ **13. Harrassment.** As a result of the fear, anxiety, and anger that many people feel in reaction to AIDS, some students or employees who are either known to be or suspected of being infected with HIV may be subjected to either emotional or physical abuse or both. Institutions of higher education should condemn all such occurrences as intolerable and respond to them quickly and effectively.